Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Prevention
Division of Workplace Programs

Workplace Managed Care
Working Glossary of Terms

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CSAP Center for Substance Abuse Prevention
Substance Abuse and Mental Health Services Administration

Workplace Managed Care
Substance Abuse Prevention and Early Intervention

Absenteeism	Time taken off from work. May be classified separately as employee sick leave, personal days, mental health days, jury duty, vacation, holidays, family illness or bereavement, Family and Medical Leave Act, workers compensation program days, short-term disability, or long-term disability. Substance abuse program theory should be used to determine which of these types of absenteeism are appropriate for analysis of the impact of a substance abuse prevention or early intervention program. Absenteeism does not include telecommuting and working off-site.
Access	The extent to which services are available for individuals who need care. Ease of access depends on several factors, including availability and location of appropriate care and services, transportation, hours of operation, and cultural factors, including languages and cultural appropriateness. For many populations access also includes insurance coverage.
Acute Care	Medical treatment rendered to individuals whose illnesses or health problems are life-threatening or debilitating, requiring immediate response, and are short-term or episodic in nature. Acute care facilities are those hospitals that predominantly serve persons requiring these kinds of services.
Adjusted Community Rating (ACR)	A community rating impacted by group-specific demographics and the group's prior experience. Also known as *prospective rating*.
Administrative Services Only Organization (ASO)	A healthcare organization that provides administrative support services only for a self-funded plan or startup MCO.
Adverse Selection	A tendency for utilization of health services in a population group to be higher than average. From an insurance perspective, adverse selection occurs when persons with poorer-than-average life expectancy or health status apply for, or continue, insurance coverage to a greater extent than do persons with average or better health expectations.
Ambulatory Care	All types of health services provided on an outpatient basis, in contrast to services provided in the home or to persons who are inpatients. While many inpatients may be ambulatory, the term ambulatory care usually implies that the patient must travel to a location to receive services that do not require an overnight stay.
At Risk	A situation in which a healthcare organization is vulnerable to providing or paying for the delivery of more services than are received through premiums or per capita payments.
Average Payment Rate	The money that the Health Care Financing Administration (HCFA) can pay an HMO.
Behavioral Health	A managed care term that applies to the assessment and treatment of problems related to mental health and substance abuse. Substance abuse includes abuse of alcohol and other drugs.

Behavioral Healthcare	A continuum of services to individuals at risk of or suffering from mental, addictive, or other behavioral disorders.
Benchmark	For a particular indicator or performance goal, the industry (healthcare or non-healthcare) measure of best performance. The benchmarking process identifies the best performance in the industry for a particular process or outcome, determines how that performance is achieved, and applies the lessons learned to improve performance elsewhere.
Benefit-cost Ratio (also known as return on investment ratio)	For workplace prevention programs, the inflation-adjusted, discounted benefits of a program or intervention divided by the inflation-adjusted discounted costs of providing and consuming the program. Values above 1.0 generally denote economically attractive programs that provide more than 1 dollar in benefits for each dollar spent on the program.
Benefit Package	The types of healthcare and other services to be provided by an employer to employees. The employer as primary payor can contract for the healthcare portion of the services. The contractor arranges for delivery of healthcare services that can include substance abuse prevention and early intervention programs.
Blind Sample	In drug testing, a sample either negative or spiked with a drug, submitted as a donor specimen in order to perform a "blind" quality control check on processes and procedures.
Bootstrapping	A process of repeated subsampling, with replacement, from a larger sample, followed by analysis of each repeated subsample. Analyses with the subsample are used to estimate variances or standard errors of variables of interest (Vogt, 1993).
Break-even Analysis	An analysis designed to determine the dollar cost or the value of benefits that would have to be assigned to make two alternative programs equally attractive (Warner and Luce, 1982).
Capitation	A method for payment to healthcare providers that is common or targeted in most managed care arenas. Unlike the older fee-for-service arrangement, in which the provider is paid per procedure, capitation involves a prepaid amount per month to the provider per covered member, usually expressed as a PMPM (per member per month) fee. The provider is then responsible for providing all contracted services required by members of that group during that month for the fixed fee, regardless of the actual charges incurred. In such an arrangement, the provider is now *at risk*, picking up risk that the payor or employer used to have exclusively in fee-for-service or indemnity arrangements.

Carve-Out	A strategy for the employer in contracting or providing managed care services in which a portion of the benefit (such as a behavioral health benefit) is separated (carved-out) from the overall medical benefit. A second organization is contracted under a separate agreement to provide these benefits. The term "carve-out" usually refers to a managed behavioral healthcare organization; many HMOs and insurance companies adopt this strategy because they do not have in-house expertise related to behavioral health. Carve-out vendors may be specialized units within larger managed care organizations or they may be independent companies.
Case Management	The monitoring and coordination of treatment rendered to covered persons with a specific diagnosis or requiring high-cost or extensive services. The goal is to achieve optimum patient outcome in the most cost-effective manner.
Case Mix	The overall clinical diagnostic profile of a defined population, which influences intensity, cost, and scope of healthcare services typically provided.
Case Rate	A flat fee paid for a patient's treatment based on the diagnosis and/or presenting problem. For this fee the provider covers all of the services the patient requires for a specific period of time. Also referred to as "bundled rate" or "flat fee-per-case." Very often used as an intervening step prior to capitation. Diagnostic Related Groups (DRGs) are an example of a case rate.
Censored Data	Data about an event or phenomenon of interest that are unavailable for periods of time or groups of people. For example, medical expenditures may be unavailable for persons who switch health plans, or for time periods before or after employment or some other event of interest, such as the employer changing the healthcare provider.
Certificate of Need	A certificate of approval issued by a governmental agency to an organization that proposes to construct or modify a healthcare facility, incur a major capital expenditure, or offer a new or different health service.
Certification of Authority	The State-issued operating license for an HMO.
Chain-of-Custody Form	In drug testing, the process used to track the handling and storage of a urine specimen for a drug test from time of collection to time of disposal.
Charges	The prices of healthcare services or other goods and services imposed by suppliers of those services. Charges typically exceed the costs of producing those services and sometimes reflect additional moneys needed to recoup bad debt or to offset losses or lower payments from some customers.

Claims Review	The method by which an enrollee's healthcare service claims are reviewed prior to reimbursement. The purpose is to validate the medical necessity of the provided services and to be sure the cost of the service is not excessive.
Closed Panel	Preferred Provider Organization in which enrollees can use only a specified group of providers in order to receive benefits.
Coinsurance	The portion of the covered healthcare cost for which the person insured has the responsibility to pay, usually based on a fixed percentage; a percentage of cost to be paid by the insured, having already paid the maximum deductible for the year. (Source: Rognehaugh R, The Managed Care Dictionary)
Collection Site	In drug testing, a place where a donor provides a urine specimen; includes the work area for the collector and the rest room, toilet stall, or partitioned area used to give the donor privacy while providing a specimen.
Community Oriented Primary Care	An approach to primary care that uses epidemiologic and clinical skills in a complementary fashion to tailor programs to meet the particular health needs of a defined population.
Consumer	An individual who receives care, who purchases care directly, or who selects among health plans purchased on his or her behalf by an employer or another entity.
Coordinated Care Networks	Term used by the Federal Government to describe managed care.
Coordination of Benefits (COB)	Provisions and procedures used by third-party payers to determine the amount payable to each payer when a claimant is covered under two or more group plans.
Copayment	The portion of the covered healthcare cost for which the person insured has the responsibility to pay, usually as a fixed fee for a specific service type (e.g., $10 per doctor visit).
Corporate Health Management Programs	Health promotion and disease prevention/wellness programs that use health education techniques to promote employee health. These programs usually include components such as exercise regimens, health-risk appraisals, weight control, nutrition information, stress management, disease screening, and smoking cessation.
Cost-based Reimbursement	Method of reimbursement in which third parties pay providers for services provided based upon the documented costs of providing that service.

Cost-benefit Analysis (CBA)	A systematic method for valuing over time the monetary costs and consequences of producing and consuming substance abuse program services. Results from a CBA are often provided in terms of a net present value figure, which shows the difference in inflation-adjusted, discounted costs and benefits of the program in today's dollars or in the dollars of a base year of interest. Results may also be shown in terms of an internal rate of return or a benefit-cost ratio. The data is used in determining the content of a benefit package.
Cost-effectiveness Analysis (CEA)	A systematic method for valuing over time the monetary costs and non-monetary consequences of producing and consuming substance abuse program services. Results from a CEA are often shown in terms of total costs and total levels of effectiveness (e.g., total quality adjusted life-years saved or total numbers of substance abuse cases avoided), or in terms of cost per unit of effectiveness. This data is used by employers to determine contents of a benefits package.
Cost-Sharing	Health insurance practice that requires the insured person to pay some portion of covered expenses (e.g., deductibles, coinsurance, and copayments) in an attempt to control utilization.
Cost-Shifting	Charging one group of patients more in order to make up for underpayment by others. Most commonly, charging some privately insured patients more in order to make up for underpayment by Medicaid or Medicare.
Covered Days	Maximum number of days for which an insurer will reimburse for services rendered. Days may be limited per episode of illness, per year, per lifetime, or per length of policy.
Covered Lives	Individuals having health insurance coverage under a particular contract, payer, or provider group. In the private sector, this refers to employees and family members.
Credentialing	The process of reviewing a practitioner's credentials, i.e., training, experience, or demonstrated ability, for the purpose of determining if criteria for clinical privileging are met.
Cultural Competence	Actions that indicate an awareness and acceptance of the importance of addressing cultural factors while providing care; ability to meet the needs of clients and patients from diverse backgrounds.
Data Warehouse	A component of a computer-based patient record that accepts, files, and stores clinical data over time from a variety of intervention systems for the purposes of developing population-based practice guidelines, outcomes management, and research.
Deductible	The minimum threshold payment that must be made by a health plan enrollee each year before the plan begins to make payments on a shared or total basis. (Source: Rognehaugh R, The Managed Care Dictionary)

Demand-side Management	Use of employer-provided health education, wellness, and client empowerment programs to assist members to make cost-effective healthcare decisions, thereby decreasing unnecessary utilization and costs. These programs may be part of a carve-out service.
Diagnostic Related Groups (DRGs)	A payment system that reimburses healthcare providers a fixed amount for all care in connection with a standard diagnostic category. The DRG system was instituted by Medicare and is now used by many insurance companies. It is a form of case rate payment system.
Discount Rate	The rate at which future dollars or future units of effectiveness are devalued, relative to current dollars or units of effectiveness.
Discounting	The process of devaluing future dollars or units of effectiveness to reflect preferences for dollars or goods or services now, versus in the future.
Disease Management Programs	Comprehensive, integrated programs for managing patients' disease conditions. These programs usually target specific disease conditions for which there are effective, evidence-based practice guidelines, and are designed for diseases such as depression, diabetes, arthritis, hypertension, and heart disease.
Drug Free Workplace Act	The 1988 Federal act that laid the groundwork for subsequent regulation of workplace drug testing.
Drug Utilization Review	A review to establish the medical appropriateness of medications given by providers to patients for particular medical conditions; performed by peers with feedback and education given to the providers, as appropriate.
Dual Diagnosis	Identification of dual diseases, disorders, or injuries, commonly used to describe individuals diagnosed with both mental disorders and addictive diseases.
Early Intervention	Refers to identifying persons at high risk prior to their having a serious consequence, or persons at high risk who have had limited serious consequences related to substance use on the job, or having a significant personal, economic, legal, or health/mental health consequence, and providing these persons at high risk with appropriate counseling, treatment, education, or other intervention.
Effect Size	The magnitude of a relationship between the dependent and independent variables in the population, or the degree of departure from the null hypothesis. Typical measures of effect size include *d*, eta, and *r*.
Eligible Employee	An employee who qualifies to receive health benefits through his/her employer.
Employee Assistance Program (EAP)	Programs to assist employees, their family members, and employers in finding solutions for workplace and personal problems. The EAP may be provided directly by the employer or be part of the healthcare contract

	with a managed care organization or managed behavioral healthcare organization.
Employee Assistance Program (EAP), Components of	An EAP program may include some or all of the following components: employee education, supervisor training, drug testing, needs assessments, wellness programs, support for parents, health fairs, peer-to-peer counseling, interactive Web sites, health risk appraisals, newsletters, and employee seminars and information campaigns.
Employee Retirement Income Security Act of 1974 (ERISA)	Also called the Pension Reform Act, this act regulates the majority of private pension and welfare group benefit plans in the United States. It sets forth requirements governing, among many areas, participation, crediting of service, vesting, communication and disclosure, funding, and fiduciary conduct.
Enrollment	The total number of covered persons (employees and their dependents) enrolled in a health plan. Also refers to the process by which a health plan signs up groups and individuals for membership, or to the number of enrollees who sign up in any one group.
Exclusive Provider Organization	A plan in which the patient must remain in the network to receive benefits (out-of-network costs are paid by the patient); a plan regulated under State insurance statute that provides coverage only for contracted providers and does not extend to non-preferred-provider services.
Full Service Employee Assistance Program (EAP)	A comprehensive EAP with a human resource management consultation orientation; typically well-funded and well-staffed; most are offered internally.
Gatekeeper Model	A situation in which a primary care provider, the "gatekeeper," serves as the consumer's contact for healthcare and referrals. Also called *closed access* or *closed panel*.
Group Model HMO	A healthcare model involving contracts with physicians organized as a partnership, professional corporation, or other association. The health plan compensates the medical group for contracted services at a negotiated rate, and that group is responsible for compensating its physicians and contracting with hospitals for care of their patients.
Health Care Financing Administration (HCFA)	The Federal agency that administers the Medicare, Medicaid, and Child Health Insurance Programs. HCFA provides health insurance for more than 74 million Americans through Medicare, Medicaid, and Child Health. The majority of these individuals receive their benefits through the fee-for-service delivery system. However, an increasing number are choosing managed care plans. HCFA is working to maintain and measure quality of care in managed care through HEDIS measures.

Health Insurance Organization (HIO)	HIOs act as fiscal intermediaries between State Medicaid agencies and healthcare providers. They receive a per capita payment from a Medicaid agency to finance the care of Medicaid enrollees. As with HMOs, they assume the risk of a loss if the payment is inadequate to cover a beneficiary's healthcare expenses. Unlike HMOs, however, HIOs typically do not deliver care. Since 1985, Congress has subjected HIOs engaged in full-risk contracting to the same regulatory standards as HMOs. HIOs that do not offer a comprehensive set of services, however, face fewer regulatory requirements. States contracting with HIOs for a less-than-comprehensive set of services must only address such issues as the term of the capitation arrangement, renegotiation, and distribution of shared savings.
Health Maintenance Organization (HMO)	An organized system of healthcare that provides a comprehensive range of healthcare services to a voluntarily enrolled population in a geographic area on a primarily prepaid and fixed periodic basis. An HMO contracts with healthcare providers, e.g, physicians, hospitals, and other health professionals. Plan members are required to use participating providers for all health services. Model types include staff, group practice, network, and IPA. Under the Federal HMO Act, an entity must have three characteristics in order to call itself an HMO: 1. An organized system for providing people healthcare services, 2. An agreed-upon set of basic supplemental health and treatment services, and 3. A voluntarily enrolled group of people.
Health Plan Employer Data and Information Set (HEDIS)	A set of performance measures designed to standardize the way health plans report data to payers. HEDIS currently measures five major areas of health plan performance: quality, access and patient satisfaction, membership utilization, finance, and descriptive information on health plan management. HEDIS guidelines are published by HCFA, which oversees federally funded healthcare.
Health Promotion Program	In the worksite, a program designed to improve employee health and productivity and to save the company money.
Heavy Drinker	Someone who reports having five or more drinks on five or more occasions in the past 30 days. A form of alcohol abuse.
HHS Certified Laboratory	The term used to describe a laboratory that is certified by the Department of Health and Human Services and that participates in the National Laboratory Certification Program.
Horizontal Integration	Merging of two or more firms at the same level of production in some formal, legal relationship. In hospital networks, this may refer to the grouping of several hospitals, the grouping of outpatient clinics within the hospital, or a geographic network of various healthcare services. Integrated systems seek to integrate vertically with some organizations and

	horizontally with others.
Imputation	The process of replacing missing data. May be done logically (based on other existing data) or with statistical techniques based on variables that are correlated with the variable and the missing data.
Incremental Cost-Effectiveness Ratio	The difference in the inflation-adjusted, discounted average costs of two programs, divided by the difference in discounted average levels of effectiveness of the two programs.
Incremental Net Benefit Value	The difference in the inflation-adjusted, discounted average benefits and costs of two alternative programs.
Indicated Prevention	A strategy designed for persons who are identified as having minimal but detectable signs or symptoms or precursors of some illness or condition, but whose condition is below the threshold of a formal diagnosis of the condition.
Indicator	A defined, measurable variable used to monitor the quality or appropriateness of an important aspect of patient care. Indicators can be activities, events, occurrences, or outcomes for which data can be collected to allow comparison with a threshold, a benchmark, or prior performance.
Individual Practice Association (IPA) Model HMO	A healthcare model that contracts with an entity, which in turn contracts with physicians to provide healthcare services in return for a negotiated fee. Physicians continue in their existing individual or group practices and are compensated on a per capita, fee schedule, or fee-for-service basis.
Integrated Delivery System	A system of providers and diverse organizations working collaboratively to coordinate a full range of care and services within a community.
Integrated Health Plan	A single entity serving as an integrated delivery network that is fully responsible for obtaining and managing payer contracts, assuming healthcare risk, collecting revenue, and asset control by lease or ownership.
Integrated Service Delivery (ISD)	A generic term referring to a joint effort of physician/hospital integration for a variety of purposes.
Integration	A concept describing how previously separate organizations, functions, and/or caregivers are blending their services and operations to function more efficiently and effectively in offering a seamless system of care within which consumers can easily move.
Intent-to-treat Design	An evaluation design in which analyses are conducted upon the basis of a treatment or comparison group assigned or chosen at baseline, regardless of how long observations remained in that group.
Internal Rate of Return	The discount rate associated with a net present value figure of $0. Programs with higher internal rates of return are more economically attractive.

Internal Validity	Refers to the ability to make statements about causal relationships between variables. Internal validity threats may diminish the truthfulness of those statements.

The International Classification of Diseases, Ninth Revision (ICD-9)	The ICD-9 system is a classification system that groups related disease entities and procedures for the reporting of statistical information. Responsibility for maintenance of the classification system is shared between the National Center for Health Statistics (NCHS), which handles diagnosis classification, and the Health Care Financing Administration (HCFA), which handles procedure classification.
Long-term Disability Expenditures	Includes salary continuation payments for those covered by insured, self-administered, or trust plans (Source: U.S. Chamber of Commerce definition, 1995).
Managed Behavioral Healthcare	Any of a variety of strategies to control behavioral health (i.e., mental health and substance abuse) costs while ensuring quality care and appropriate utilization. Cost-containment and quality assurance methods include the formation of preferred provider networks, gatekeeping (or precertification), case management, relapse prevention, retrospective review, claims payment, and others. In many employer-negotiated health plans, behavioral healthcare is separated from care available in the rest of the health plan for the separate management of costs and quality of care.
Managed Behavioral Healthcare Organizations (MBHO)	An organized system of behavioral healthcare delivery, usually to defined population or members of HMOs, PPOs, and other managed care structures; also known as a behavioral health carve-out.
Managed Care	For Workplace Managed Care definitional purposes, managed care includes the following four characteristics: (1) a network of healthcare providers operating within some degree of management control; (2) assumption of financial risk by the provider network or health benefit intermediary; (3) management of service utilization through guidelines, protocols, and case management techniques; and (4) provision of preventive care.
Managed Care Organization (MCO)	A generic term applied to a managed care plan; may be in the form of an HMO, PHO, PPO, EPO, or other structure.
Managed Healthcare Plan	A healthcare plan that integrates financing and management with the delivery of healthcare services to an enrolled population; employs or contracts with an organized provider network that delivers services and which (as a network or individual provider) either shares financial risk or has some incentive to deliver quality, cost-effective services; and uses an information system capable of monitoring and evaluating patterns of covered persons' use of healthcare services and the cost of those services.
Management Services Organization (MSO)	An organization that provides practice management, administration, and support services to individual physicians or group practices. MSOs are typically owned by hospital(s) or investors.

Mandatory Guidelines	In drug testing, the term used to refer to the Mandatory Guidelines for Federal Workplace Drug Testing Programs initially published in the *Federal Register* on April 11, 1988, and revised on June 9, 1994, to establish the scientific and technical guidelines for Federal drug testing programs.
Maternal and Child Health Programs (MCHP)	A State service organization to assist children under 21 years of age who have conditions leading to health problems
Mediating	A term that describes a third variable's relationship to a dependent and an independent variable, in which the third variable represents the generative mechanism through which the independent variable is able to influence the dependent variable of interest. A variable functions as a mediator when it meets the following criteria: (1) variations in the levels of the independent variable significantly account for variations in the presumed mediator; (2) variations in the mediator significantly account for variations in the dependent variable; and (3) a previously significant relationship between the independent and the dependent variable is lost or greatly attenuated when the variance accounted for by the independent/mediator relationship is removed.
Medical Necessity	The evaluation of healthcare services to determine if they are medically appropriate and necessary to meet basic health needs, consistent with the diagnosis or condition and rendered in a cost-effective manner, and consistent with national medical practice guidelines regarding type, frequency, and duration of treatment.
Medical Review Officer	In drug testing, a licensed medical doctor specially trained in substance abuse who is responsible for receiving, interpreting, and evaluating drug test results.
Member Assistance Program	A human risk management program that focuses on lowering behavioral and healthcare costs by proactively reducing demand for treatment. Also known as “demand reduction” or “demand management program.”
Memorandum for Record (MFR)	In drug testing, a statement prepared by an individual that provides or corrects information on any documents associated with a drug test.
Moderating	A term that describes a third variable's relationship to a dependent and an independent variable, in which the third variable partitions the independent variable into subgroups that establish its domains of maximal effectiveness in regard to the dependent variable. The moderator may be qualitative or quantitative, and it affects the direction and/or strength of the relation between the independent and the dependent variable. Within an ANOVA framework, the moderator effect can be represented as an interaction between an independent variable and a factor that specifies particular conditions for its effect.

Morbidity	An actuarial determination of the incidence and severity of sicknesses and accidents in a well-defined class or classes of persons.

Mortality	An actuarial determination of the death rate at each age as determined from prior experience.
National Committee for Quality Assurance (NCQA)	A national organization founded in 1979 and composed of 14 directors representing consumers, purchasers, and providers of managed healthcare. It accredits quality assurance programs in prepaid managed healthcare organizations, and develops and coordinates programs for assessing the quality of care and service in the managed care industry.
Net Present Value	The inflation-adjusted, discounted benefits of a program or intervention, minus the inflation-adjusted, discounted costs of producing and consuming it, expressed in today's dollars or the dollars of a base year of interest.
Network Model HMO	An HMO type in which the HMO contracts with more than one physician group, and may contract with single- and multi-specialty groups. The physician works out of his/her own office. The physician works out of share in utilization savings, but does not necessarily provide care exclusively for HMO members.
Observer	In drug testing, the individual who watches the donor urinate into a collection container or specimen bottle when a direct-observed collection is required.
Opportunity Cost	The value of resources used to produce or consume goods or services in their next best alternative use.
Organized Delivery Systems	Proposed networks of providers and payors that would provide care and compete with other systems for enrollees in their region. Systems could include any providers and/or sites that offer a full range of preventive and treatment services.
Outcome Measures	Assessments that gauge the effect or results of services provided to a defined population. Outcomes measures include the consumers' perception of restoration of function, quality of life, and functional status, as well as objective measures of mortality, morbidity, and health status.
Outlier Data	Extremely high or low values of a variable of interest.
Payor	The party, including employers, government agencies, and insurance companies, that purchases the health services provided to consumers.
Performance Goals	The desired level of achievement of standards of care or service. These may be expressed as desired minimum performance levels (thresholds), industry best performance (benchmarks), or the permitted variance from the standard. Performance goals usually are not static but change as performance improves and/or the standard of care is refined.

Performance Measure(s)	Methods or instruments to estimate or monitor the extent to which the actions of a healthcare practitioner or provider conform to practice guidelines, medical review criteria, or standards of quality.
PMPM	Stands for "per member per month," a fixed rate paid per enrolled member under a managed care contract for the provision of healthcare. This is the form that a capitated payment usually takes.
Physician-Hospital Community Organization	Similar to a physician-hospital organization, with the addition of community governance representation.
Physician-Hospital Organization (PHO)	An IPA (individual practice association) associated with and often initiated by a hospital which provides management services; features a contracting mechanism for obtaining "covered lives," generally with 50:50 physician and hospital control and hospital financing.
Point-of-Service (POS)	A type of healthcare benefit plan in which the insured person can choose to use a nonparticipating provider at a reduced coverage level and with more out-of-pocket cost. Such POS plans combine HMO-like systems with indemnity systems. Often known as open-ended HMOs or PPOs, these plans permit the insured to choose providers outside the plan, yet are designed to encourage the use of network providers. One of the most popular plans with consumers and employers, POS services represent the area of greatest HMO growth.
Power	In statistics, the probability of rejecting the null hypothesis. In a statistical comparison of two groups, the power of a statistical test is the probability of correctly identifying a difference between the groups, given that the difference does in fact exist. Power = 1-ß, where ß is type II error.
Practical Significance	A result or value of sufficient magnitude that it is important to program providers, clients, employers, policy makers, or other stakeholders.
Practice Guidelines	Systematically developed statements on healthcare practice that assist healthcare providers and consumers in making decisions about appropriate healthcare for specific situations or conditions. Managed care organizations frequently use these guidelines to evaluate appropriateness and medical necessity of care.
Preferred Provider Organization (PPO)	A network discount, fee-for-service provider arrangement with incentives to stay inside the network; allows healthcare services outside of the PPO network at an increased copayment and/or deductible; has structured quality and utilization management.

Prevention	The public health model of prevention includes primary, secondary, and tertiary prevention (defined elsewhere in this glossary). An Institute of Medicine (IOM) committee (1994) set forth another definition in which prevention refers to those interventions that take place before the onset of a disorder. IOM classifies preventive interventions as: *Universal preventive interventions:* Target the general public or an entire population not identified on the basis of individual risk *Selective preventive interventions:* Target populations whose risk of a disorder is significantly higher than average at present or over a lifetime *Indicated preventive interventions:* Target high risk individuals who have minimal but detectable signs or symptoms which may lead to a mental disorder.
Prevention Research	The U.S. Public Health Service definition defines prevention research as research designed to show results directly applicable to interventions to prevent occurrences of disease or disability.
Preventive Care	Comprehensive healthcare emphasizing priorities for prevention, early detection, and early treatment of conditions, generally including risk assessment appraisals, routine physical examinations, immunizations, and well-baby care.
Primary Care	Basic or general healthcare, traditionally provided by family practice, pediatrics, and internal medicine.
Primary Care Case Management (PCCM)	Case management that requires a gatekeeper to coordinate and manage primary care services, referrals, pre-admission certification, and other medical or rehabilitative services. The primary advantage of PCCM for Medicaid eligibles is increased access to PCP while reducing use of hospital outpatient departments and emergency rooms. (There is encouragement within Medicare Choices to provide PCP coordination for patients being treated by a wide variety of specialists but who no longer have a PCP for oversight.)
Primary Care Provider (PCP)	A term used to denote the health care provider who typically delivers health care services to the patient, such as a family practitioner, general internist, pediatrician, and sometimes an ob/gyn. Generally, under managed care, a PCP supervises, coordinates, and provides initial ambulatory medical care, acting as a “gatekeeper” for the initiation of all referrals for non-urgent specialty care.
Primary Prevention	Strategies designed to decrease the number of new cases of a disorder or illness

Productivity	Defined generally by economists as the amount of output of a good or service produced per unit of input needed to produce it. May be measured more easily in manufacturing processes in terms of goods or units produced per staff member or machine. More difficult to measure for services, because the boundaries that define services may be less well understood or the quality of services produced may be more difficult to measure.
Productivity Correlates	Factors related to productivity, such as various forms of absenteeism, restricted activity days, employee morale, production delays, job tenure, etc.
Propensity Score	In the context of performing adjustments for selection bias, the propensity score is the predicted probability that each client participates in a substance abuse program.
Provider (Participating Provider)	Individuals and/or organizations that directly deliver prevention, treatment, and maintenance services to consumers within the defined plan. Depending upon the arrangement, usually involves contracts.
Providers Service Organization/ Provider Sponsored Network (PSN)	A formal affiliation of healthcare providers organized and operated to provide a full range of healthcare services; a term used in draft language of the 1996 budget discussions of House and Senate proposals that would allow Medicare to contract directly with PSNs on a full-risk capitated basis in a way that would "cut some HMOs out of the middle" depending on the ultimate language. The degree to which PSNs must be subject to licensing, financing, and insurance considerations, as regulated by State insurance commissioners, will determine the number of providers to qualify, as compared to the more rigid HMO standards under which provider networks must currently qualify.
Quality of Care	The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.
Quality-Adjusted Life-Year	Measurement unit to define health outcomes that result from medical or surgical care, expressed in terms of the number of years of life in a less-desirable health condition as compared to years of full health; if the quality of life for a bedridden patient is 50 percent with a life expectancy of 10 years, the measurement would be 5 quality-adjusted life-years. As the U.S. system of medicine becomes more focused on how to allocate limited healthcare resources, more attention will be given to this and other measures of intervention benefits.
Quality Assurance (QA)	A formal set of measures, requirements, and tasks to monitor the level of care being provided. Such programs include peer or utilization review components to identify and remedy deficiencies in quality. The program must have a mechanism for assessing effectiveness and may measure care against preestablished standards.

Randomization Test	A process of repeated testing used to eliminate P-values for statistical tests with small samples.
Report Card on Healthcare	An emerging tool that can be used by policymakers and healthcare purchasers such as employers, government bodies, employer coalitions, and consumers to compare and understand the actual performance of health plans. The tool provides health plan performance data in major areas of accountability, such as healthcare quality and utilization, consumer satisfaction, administrative efficiencies and financial stability, and cost control.
Risk Analysis	The process of evaluating expected healthcare costs for a prospective group and determining what product, benefit level, and price to offer in order to best meet the needs of the group and the carrier.
Risk Sharing	The distribution of financial risk among parties furnishing a service. For example, if a hospital and a group of physicians from a corporation provide healthcare at a fixed price, a risk-sharing arrangement would entail both the hospital and the physician group being held liable if expenses exceed revenues.
Secondary Prevention	Prevention strategies designed to lower the rate of established cases of a disorder or illness in the population (prevalence).
Selection Bias	A bias in the estimate of a program effect that arises from the inability to separate the impact of the program on an outcome of interest from the impact of other factors that are correlated with program participation and outcome measures. Such bias often occurs in nonrandomized or poorly randomized settings, resulting in treatment and comparison groups that differ on measurable and unmeasurable factors. For example, self-referral to (or self-selection into) a substance abuse program may result in substantial differences between substance abusers who participate in the program and those who do not. These differences, along with participation status, may influence observed outcomes.
Selective Prevention	Strategy designed for individuals who are members of population subgroups whose risk of developing an imminent or lifetime disease or disability is significantly above average.
Sensitivity	In the context of the accuracy of diagnosis coding, sensitivity refers to the ability to identify persons with a particular disorder using claims data or survey data among persons who really have that disorder.
Sensitivity Analysis	A process of repeating the CBA or CEA several times, each time varying one or more assumptions necessary to carry out the analysis, to see how robust the results are to these changing assumptions.

Service Utilization	A description, usually statistical, of the level, frequency, and necessity of services actually used by consumers. Generally aggregated into population measures, rather than individual consumer measures.
Short-term Disability Expenditures	Includes company payments for sickness and accident benefits beyond any sick leave or other days not included in the short-term disability program. For example, many companies do not pay for the first five consecutive absence days under a short-term disability program.
Social Health Maintenance Organization	Federally funded Medicare demonstration project for the elderly; provides comprehensive health and long-term care benefits to Medicare beneficiaries. Unlike other Medicare-enrolling HMOs, care in a social HMO is reimbursed at 100 percent.
Specificity	In the context of the accuracy of diagnosis coding, specificity refers to the ability to identify those who do not have a disorder of interest using claims data or survey data among those who really do not have that disorder.
Specimen	In drug testing, urine that has been provided by a donor for a drug test. The entire sample is contained in a single specimen bottle.
Split Specimen	In drug testing, a single specimen that is split into two separate specimen bottles. Split specimens are never collected from two different voids by the donor.
Staff Model HMO	A healthcare model that employs physicians to provide healthcare to its members. All premiums and other revenues accrue to the HMO, which compensates physicians by salary and incentive programs.
Stakeholders	Persons or groups who have strong interest about the design, function, or outcomes of a healthcare program or intervention.
Statistical Power	The ability to accurately detect differences between groups or relationships between variables.
Substance Abuse	Refers to the abuse of alcohol and/or drugs. There are many definitions. The DSM-IV definition is: The maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following occurring within a 12-month period: * recurrent substance use resulting in a failure to fulfill major role obligations; * recurrent substance use in situations in which it is physically hazardous; * recurrent substance-related legal problems; and * continued substance use despite having persistent or recurrent social or interpersonal problems caused by or exacerbated by the effects of the substance.

Substance Abuse Prevention and Early Intervention Program (components of)	There are six key components: (1) Written company/managed care policy that includes prevention and early intervention; (2) Substance abuse education for covered lives; (3) A clearly identified locus (e.g., managed care corporation, personnel, human resources, EAP, etc.) for prevention and early intervention activities; (4) Program with all covered lives having access to prevention/early intervention programs and activities; (5) Capacity for prevention and early intervention; and (6) Trained medical/behavioral interventionists for prevention and early intervention.
Suppressor or Masking Variable	A variable that may have a low correlation with a dependent variable, but which, when entered in a multiple regression analysis, leads to improvement in the predictive power of another predictor in the equation. The inclusion of the variable is thought to control for irrelevant variance, that is, variance that it shares with the predictors but which may not be shared with the dependent variable.
Tamper-evident Label/Seal	In drug testing, the label that is used to seal a urine specimen bottle. In addition to sealing the specimen bottle, it also provides an appropriate specimen number and space for the donor to initial and date the label.
Tertiary Prevention	Strategies designed to decrease the amount of disability associated with an existing disorder or illness.
Third-party Administrator (TPA)	Usually an out-of-house professional firm providing healthcare administrative services, such as paying claims, collecting premiums, and carrying out other administrative support services, for employee benefit plans. (Synonyms: administrative agent, carrier, insurer, underwriter).
Turnover Rate	Includes all permanent separations, whether voluntary or involuntary. Monthly turnover rates are calculated by employers and collected as part of the Bureau of National Affairs' Quarterly Employment Survey. BNA then calculates the monthly median rates and the average of monthly median rates for the year. Monthly rates are calculated as (number of separations during month / average number of employees on payroll during the month) * 100. (Source: Bureau of National Affairs' definition, 1995). SAMHSA grantees may wish to calculate separate turnover rates for voluntary and involuntary separations if their programs are more likely to affect one type of turnover than another.
Type I Error	The error committed when a true null hypothesis is rejected.

Type II Error	The error committed when a false null hypothesis is accepted.
Universal Prevention	Prevention designed for everyone in the eligible population, both the general public and all members of specific eligible groups.
Utilization Management (UM)	The process of evaluating the necessity, appropriateness, and efficiency of healthcare service. A review coordinator or medical director gathers information about the proposed hospitalization, service, or procedure from the patient and/or providers, then determines whether it meets established guidelines and criteria, which may be written or automated protocols approved by the organization. A provider or integrated delivery network that proves it is skilled in UM may negotiate more advantageous pricing, if UM is normally performed by the HMO but could be more effectively passed downward at a savings to the HMO.
Utilization Review (UR)	The evaluation of the medical necessity and the efficiency of healthcare services, either prospectively, concurrently, or retrospectively; contrasted with utilization management in that UR is more limited to the physician's diagnosis, treatment, and billing amount, whereas UM addresses the wider program requirements.
Vertical Integration	An organization of production whereby one business entity controls or owns all stages of the production and distribution of goods or services. In healthcare, vertical integration can take many forms, but generally implies that physicians, hospitals, and health plans have combined their organizations or processes in some manner to increase efficiencies, increase competitive strength, or to improve quality of care. Integrated delivery systems or healthcare networks are generally vertically integrated.
Wellness Program	Programs, typically oriented toward healthy lifestyle and preventive care, that may decrease health-care utilization and costs. From an employer perspective the emphasis is on keeping employees healthy.
Workers Compensation Payments	Includes actual disbursements for injuries and illnesses covered under Workers Compensation program rules.
Workplace Injuries and Illnesses	Nonfatal occupational illnesses or injuries that involve one or more of the following: loss of consciousness, restriction of work or motion, lost worktime, transfer to another job, or medical treatment (other than first aid).

Workplace Managed Care (WMC)	In WMC, workplaces integrate their substance-abuse prevention and early-intervention programs, strategies, and activities for employees and their families (covered lives). Integrated activities frequently include internal and external workplace and workplace-related components: employee assistance programs (EAPs), human resources, security, management, and managed care organizations and providers (primary and behavioral health care). Services may be received in various locations and through face-to-face encounters (e.g., at the workplace, physician's office, health fairs, etc.) or multi-media (e.g., video, telephone, Internet, publications, etc.). It is the strategy of integrating these elements and agents that constitutes the WMC approach to providing substance abuse prevention and early intervention to employees and their families.
Wraparound Services	Services that address consumers' total healthcare needs in order to achieve health or wellness. These services "wrap around" core clinical interventions, usually medical. Typical examples include such services as financial support, transportation, housing, job training, specialized treatment, or educational support.

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